DOCUMENT RESUME

ED 394 651 PS 024 001

AUTHOR Earle, Ralph B.
TITLE Helping To Prevent Child Abuse--and Future Criminal Consequences: Hawai'i Healthy Start. Program Focus.
INSTITUTION Department of Justice, Washington, D.C. National Inst. of Justice.
REPORT NO NCJ-156216
PUB DATE Oct 95
NOTE 13p.
PUB TYPE Reports - Descriptive (141)

EDRS PRICE MF01/PC01 Plus Postage.
DESCRIPTORS At Risk Persons; *Child Abuse; Child Development Centers; *Delinquency; Early Childhood Education; *Early Intervention; Home Visits; Parent Education; *Prevention; Screening Tests; Social Support Groups
IDENTIFIERS *Hawaii; *Long Term Effects

ABSTRACT

This document describes Hawai'i's Healthy Start Program, a statewide, multisite home visitation program designed to screen, identify, and work with at-risk families of newborns. Goals of the program include: (1) reducing family stress; (2) improving family functioning; (3) enhancing child health and development; and (4) preventing abuse and neglect. The Hawai'i Health Start model includes early intervention, following a child from (or before) birth through age 5; home visitations; and ongoing evaluation. Families enrolled in the program are most often young (parents under 24 years old), with one or both parents unemployed (or underemployed) and undereducated. In 1994, about 65 percent of the women participating in the program were single mothers. The program seeks to meet needs in a variety of ways, including: (1) interagency coordination and referrals; (2) a toy-lending library; (3) parent support groups; (4) a male home visitor who works with fathers; and (5) parent-child play sessions. Between July 1987 and June 1991, the program served over 2,254 families. Ninety percent of the two-year-olds enrolled in the program were immunized. Eight-five percent of the enrolled children were at an appropriate stage of development. Additionally, no instance of domestic homicide had been reported in this time frame. Contains 20 notes. (JW)

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Program Focus

ED 394 651

Helping To Prevent Child Abuse—and Future Criminal Consequences:

Hawai'i Healthy Start

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Helping To Prevent Child Abuse—and Future Criminal Consequences: Hawai'i Healthy Start

By Ralph B. Earle, Ph.D.

Traditionally, the prevention of child abuse and neglect has fallen under the purview of health and social service agencies. Increasingly, however, violence against children is a critical priority for criminal justice officials as well. Not only are child abuse and neglect crimes against society's most vulnerable members, they also may lead to crime perpetrated later in life by the victims themselves. Reducing the twofold effect of child abuse and neglect on the safety and well-being of American communities presents a formidable challenge for all segments of society.

Highlights

The violence committed by youths too often is traced to the abuse and neglect they suffered in their early years. The link between child maltreatment and later criminal behavior by its victims has made the criminal justice, health, and social service systems partners in prevention. As part of its research initiative on family violence, the National Institute of Justice (NIJ) is investigating interdisciplinary approaches involving children, their families, and their communities. This Program Focus describes the Hawai'i Healthy Start program, which uses home visitors from the community to provide services to at-risk families. Its goals are to reduce family stress and improve family functioning, improve parenting skills, enhance child health and development, and prevent abuse and neglect.

Of Special Interest:

■ Unlike other similar programs, Hawai'i Healthy Start follows the child from birth (or before) to age 5 with a range of services, and it assists and supports other family members.

■ To ensure systematic enrollment, Healthy Start signs up most families right after delivery of the child, although approximately 10 percent of families are enrolled prenatally.

■ Healthy Start has formal agreements with all hospitals in Hawai'i to enable it to perform postpartum screening through a review of the mother's medical record or a brief inperson interview. Fewer than 1 percent of mothers refuse to be interviewed, 4 to 8 percent later refuse offers of services, and about 7 percent cannot be located after release from the hospital.

■ Paraprofessional home visitors call on families weekly for the first 6 to 12 months. Early in the relationship, the home visitor helps parents develop an Individual Support Plan, specifying the kinds of services they want and need and the means by which to receive them.

■ As part of its oversight, the Maternal Child Health Branch requires completion of a series of Infant/Child Monitoring Questionnaires to identify problems in child development at 4, 12, 20, and 30 months. If these show developmental delays, further assessments are performed and appropriate services are offered.

■ In 1994 a confirmed child care abuse and neglect case cost the Hawai'i family welfare system $25,000 for investigation, related services, and foster care. In contrast, Hawai'i Healthy Start officials estimate an annual average cost of $2,800 per home visitor case.

■ Preliminary evaluation findings indicate that Healthy Start families have lower abuse/neglect rates and their children are developing appropriately for their ages.

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A growing amount of data appears to support the concept of a "cycle of violence" that begins with child abuse and neglect. One recent national study showed that being the victim of abuse and neglect as a child increases the chances of later juvenile delinquency and adult criminality by 40 percent. Even among children who are neglected but not abused, one in eight will later be arrested for a violent offense.[1] Children who experience severe violence in the home are approximately three times as likely as other children to use drugs and alcohol, get into fights, and deliberately damage property. Abused and neglected children are four times as likely to steal and to be arrested.[2]

Long before some victims of child abuse and neglect inflict pain and loss on others, they are caught up in a child welfare system that is costly and overburdened. For example, from 1994 to 1995 in Hawai'i, each confirmed case of child abuse or neglect cost nearly $15,000 per year for investigation and services. Foster care added another $10,000 per year. Home care for a drug-exposed child cost $18,000 per year, and foster care for that child, $46,000.[3] For both social and financial reasons, the criminal justice and family welfare systems have a strong incentive to reduce child abuse and neglect.

Although both intuition and existing scientific data indicate a predisposition to crime and violence among many abused and neglected children, more research is needed to determine the exact nature of the link, as well as the relationship of associated factors, such as socioeconomic status.[4] Nonetheless, preliminary findings underscore the need for the criminal justice system to support and work in partnership with child abuse and neglect prevention efforts and the communities they serve as a means of reducing crime in both the short term and the long run.

The Hawai'i Healthy Start Model

As part of its research initiative on family violence, the National Institute of Justice (NIJ) is interested in interdisciplinary approaches involving children, their families, and their communities.[5] The U.S. Advisory Board on Child Abuse and Neglect identified home visiting in 1991 as the most promising means for preventing the maltreatment of children. One example of this approach is Hawai'i Healthy Start, a statewide, multisite home visitation program designed to screen, identify, and work with at-risk families of newborns to prevent abuse and promote child development.

Home visitation programs have become increasingly popular in recent years as a means to address a number of social problems and individual needs. Programs designed primarily for families with newborns have diverse goals and services. The goals of Hawai'i Healthy Start are to:

- Reduce family stress and improve family functioning.
- Improve parenting skills.
- Enhance child health and development.
- Prevent abuse and neglect.

Although it shares the same name as 15 infant mortality prevention programs on the mainland, Healthy Start's services are not limited to the months before and after a child's birth. Instead, Hawai'i Healthy Start serves the child until age 5. The program includes early identification of families at risk for child abuse and neglect, community-based home visiting support and intervention services, linkage to a "medical home" and other health care services, and coordination of a wide range of community services, primarily for the parents and their newborn, but also for other family members.[6] To avoid confusion with similarly named and focused programs (see "Federal 'Healthy Start' Program" and "Healthy Families America").

Federal "Healthy Start" Program To Reduce Infant Mortality

In 1991 the U.S. Department of Health and Human Services began a 5-year program, also called "Healthy Start," to reduce infant mortality by 50 percent in 15 mainland communities. The Federal program was designed to strengthen the maternal and infant care system in these communities through six recommended activities: perinatal care, family planning and infant care, psychosocial services, facilitating services, individual development, and community development and public education.

The Federal Healthy Start program is trying to reduce deaths during the first year of life. It does not provide the child development and stress management services offered by Hawai'i Healthy Start or by the Healthy Families America programs. The Chicago Healthy Start program, however, recently adopted Hawai'i's model at four sites as part of its strategy to prevent domestic violence.

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Healthy Families America:

Home Visitation To Prevent Child Abuse and Neglect on the Mainland

In January 1992 the National Committee to Prevent Child Abuse (NCPCA), in partnership with Ronald McDonald Children's Charities (RMCC) and in collaboration with the Hawai'i Family Stress Center, launched the Healthy Families America (HFA) initiative. Building on two decades of research and the experiences of Hawai'i Healthy Start in putting that research into practice, HFA was designed to help establish home visitation programs, service networks, and funding opportunities in each State so that all new parents can receive necessary education and support. As of spring 1995, HFA programs had been implemented at 101 pilot sites in 20 States on the mainland.[7]

NCPCA, in collaboration with the Hawai'i Family Stress Center, provides training and technical assistance to HFA home visitation programs, using Hawai'i Healthy Start as one example of an effective program. NCPCA also has prepared a number of other individuals across the country to serve as trainers for State and local HFA efforts. Although each HFA site has aimed to meet the needs and build on the strengths of its community, all have embraced the 12 HFA criteria for effective programs as defined by research and the experience of Hawai'i Healthy Start.

HFA programs have been funded by a mix of private foundations, Federal funds, block grants, and State appropriations. Arizona, Indiana, and Oregon have passed multimillion dollar appropriations for statewide services.

The HFA goal is to offer all new parents in each service area at least one or two home visits. Thus far in practice, however, most programs have provided services primarily to families with the greatest needs. The programs serve a range of populations, from inner-city African Americans in Atlanta to Central American immigrants in Fairfax, Virginia.

NCPCA is coordinating efforts to help each program develop an evaluation component, including a national network of evaluators to collaborate on common outcome measures. All sites track child abuse and neglect cases and monitor child development and immunization; many sites use Nursing Child Assessment Satellite Training (NCAST) assessments.

The first HFA program to provide outcome data from an outside evaluation was in Arizona. Out of the 111 families enrolled in 1992, two families had validated reports of abuse, and one family had a validated report of neglect following the entrance of the target child in the project. The combined abuse and neglect rate (CAN) was 2.7 percent, compared with 2.1 percent for the Hawai'i families. However, the Arizona families were at higher risk than their Hawai'ian counterparts: 50 percent had a previous history of abuse (versus 38 percent in Hawai'i), and they had a higher percentage of severe risk items on the Kempe Family Stress Checklist. At age 6 months, only four of 57 children screened showed delay in one area of development; none showed delay in more than one area.[8]

the program featured in this Program Focus is referred to throughout as Hawai'i Healthy Start.

Program History

The development of Hawai'i Healthy Start was strongly influenced by the late Dr. Henry Kempe, a researcher at the University of Colorado Health Sciences Center and Director of the National Center for Prevention and Treatment of Child Abuse and Neglect in Denver. Kempe operated residential treatment and prevention programs and developed a checklist to identify families at risk of abusing or neglecting their children.

In the early 1970's Kempe screened 500 families in the Denver area and identified 100 as being at risk for child abuse and neglect. He randomly assigned these 100 families to two groups. One group received home visiting services; the other received only the usual medical services. In each group of 50, he followed 25 families for 3 years. Among the families provided services, there were no hospitalizations for abuse, although three families gave a child up for adoption. Among the 25 nonserviced families, however, five children were hospitalized variously for head injuries, scaldings, and fractures.

In 1973 Dr. Calvin Sia, a prominent pediatrician in Hawai'i, and members of Hawai'i's Child Protective Service (CPS) Advisory Committee invited Kempe to help them put together a plan for the prevention and treatment of child abuse and neglect among families in Hawai'i. One year later, Gail Breakey, current Director of the Hawai'i Family Stress Center, and Sia obtained a 3-year grant from the National Center for Prevention and Treatment of Child Abuse and Neglect to implement the home visiting program de-

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veloped by Kempe and the CPS Advisory Committee. They began a small prevention program on O'ahu, which yielded results similar to Kempe's work. Three home visitors provided emotional support and taught child development to 70 families for 12 to 18 months. Breakey's and Sia's developmental work continued with a community service grant from 1978 to 1981 to extend services to five additional sites on neighboring islands.

Healthy Start was an outgrowth of these early programs. It was designed at the request of the Hawai'i Senate Ways and Means Chairman, Mamoru Yamasaki, who was concerned with the State's increasing costs of corrections and social services. Originally intending to fund a delinquency prevention project in a high school, Yamasaki recognized the relationship between early abuse and delinquency and decided instead to begin with infants of families at risk for child abuse and neglect.

Healthy Start began in Hawai'i in July 1985 as a State-funded demonstration child abuse and neglect prevention program at a single site on O'ahu, the most populous island, with an annual budget of $200,000. The original prevention program concept was expanded to include broader implementation and more comprehensive objectives. Hawai'i Healthy Start was designed to serve all families of newborns at risk within the catchment area, follow the children to age 5, link all infants to a medical home that would serve them through childhood, and intensify the focus on parent-child attachment and interaction, child health, and child development.

After 3 years, Healthy Start had served 241 high-risk families, 176 of which were served for at least 1 year. No cases of child abuse and only four cases of child neglect were reported among the 241 families. Based on these results, between 1988 and 1990 the program was expanded through general funds appropriated by the State legislature to 13 sites across the State, with an annual budget of over $8 million for fiscal year 1995.

Administration, Budget, and Management

The Maternal Child Health Branch of the Hawai'i Department of Health administers the State appropriations, monitors the program, and evaluates the seven not-for-profit private agencies that deliver Healthy Start services. The programs conducted by the seven agencies vary in terms of budget and caseload. The smallest has an annual budget of $290,000 and serves 150 families; the largest spends over $1 million to serve 350 to 400 families each year. In 1990 actual screening, assessment, and case management services cost $2,500 per case. Where available, respite care services cost $476 per child per year.

To establish a new program, Hawai'i Healthy Start officials recommend a yearly budget of $349,000 to handle 140 cases per year, allocating about $283,000 to personnel costs, $34,000 to operating expenses, and $32,000 to overhead. This budget does not include funds for evaluation, but it would fund a program manager at $35,000, a supervisor at $30,000, one family assessment worker and six family support workers (who serve as the home visitors) from $19,000 to $21,000, and a secretary at $21,000. At this level, the supervisor would direct five home visitors and/or family assessment workers. The program manager would supervise up to three additional home visitors. Hawai'i Healthy Start maintains about a 1:5 ratio of supervisors to staff and recommends that other programs try to do the same—regardless of the level of staff training—to ensure adequate supervision critical to program success and avoid overburdening supervisors.

Clientele

In 1994 Healthy Start made initial contact with 65 percent of the more than 16,000 newborns of civilian families in the State. From these 10,485 contacts, 2,800 families (27 percent) enrolled in home visitation services. Enrolled families tend to be young (parents under 24 years old); of Hawai'ian (32 percent), Caucasian (23 percent), Filipino (18 percent), or Japanese (10 percent) ancestry; and low-income (50 percent receive welfare), with the father unemployed and the mother undereducated. Thirty-eight percent of the families have a history of substance abuse; 43 percent have a history of domestic violence; and 22 percent are homeless or living in temporary, overcrowded conditions with other families. About 65 percent of enrolled women are single.

Service Flow

Enrollment. Hawai'i Healthy Start enlists most families immediately after delivery of the child, as this is the best way of ensuring systematic enrollment. About 10 percent of families are enrolled prenatally through contacts with clinics, obstetricians, and public health nurses. Private physicians are encouraged to refer pregnant women who may need services to the program. For those who enter the program before a child's birth, Hawai'i Healthy Start has developed a curriculum for home visitors to use with women and those of their husbands or partners who are involved with the family. Home visi-

Healthy Start Screening Instrument

1. Marital Status: Single, Separated, Divorced
2. Partner Unemployed
3. Inadequate Income or Unknown
4. Unstable Housing
5. No Phone
6. Education Under 12 Years
7. Inadequate Emergency Contacts
8. History of Substance Abuse
9. Late or No Prenatal Care
10. History of Abortions
11. History of Psychiatric Care
12. Unsuccessful Abortion
13. Relinquishment for Adoption
14. Marital or Family Problems
15. History of Current Depression

tors help them understand the physiological and emotional effects of pregnancy and prepare them for taking care of the baby. Hawai'i Healthy Start also stresses regular prenatal care and assists enrolled women in identifying and using a primary care physician for both preventive care and later infant treatment.

Screening at birth. Throughout Hawai'i, postpartum screening begins in the hospital with either a review of the mother's medical records or a brief inperson interview. The program has formal agreements with each hospital. Using the Healthy Start screening questionnaire, the family assessment worker checks 15 items as true, false, or unknown. ("See Healthy Start Screening Instrument.")

Three situations prompt an assessment interview:

- The mother is single, separated, or divorced; had poor prenatal care; or sought an abortion.
- Responses for two or more items are "true."[9]
- Responses for seven or more items are "unknown."

This first screening determines who requires an indepth assessment interview. One family assessment worker can perform 550 screenings and 225 assessments per year.

Assessment. If the screening suggests the need for assessment, the family assessment worker visits the mother and introduces her to the Healthy Start program. If the father is present, he is also interviewed. All interviews are voluntary. According to the family assessment worker supervisor at Kapiolani Medical Center for Women and Children (where about half of all children on O'ahu are born), mothers of newborns are usually quite willing to talk about any concerns having to do with their home situations. Less than 1 percent refuse to be interviewed.

During a casual conversation, which takes from 45 minutes to an hour, the family assessment worker covers the ten topics on the Kempe Family Stress Checklist. Immediately after leaving the room, the family assessment worker scores the ten items as normal (0), mild (5), or severe (10). This screening assessment identifies the *factors* that place the family at high risk for abuse and neglect. Families scoring above 25 are invited and encouraged to become enrolled in services. Depending on the community served, about 85 to 95 percent accept, 4 to 8 percent refuse, and about 7 percent cannot be found after they leave the hospital, usually because they move and cannot be contacted. (Some families who score in the 10–20 point range are assessed as "clinically positive" if the family assessment worker senses that the mother or father is not forthcoming. These families are offered services.) If a family scores above 40 and does not accept services, the supervisor will consider referring the family to the Child Protective Services.

The first home visit. Paraprofessional home visitors call on families weekly (or more frequently, if needed) for the first 6 to 12 months. The first 1½ hour visit is spent describing the program and the role of the home visitor. The home visitor usually starts the conversation with something like the following:

> I work with the Healthy Start program. I have new information about babies that I didn't know about when I was raising my kids. It can make being a mother easier, but not easy! Also, you can look at me as your information center about this community. I live here, too, and I didn't know about WIC [Special Supplemental Food Program for Women, Infants, and Children] or the well baby clinic before I started this job.
>
> I hope you will learn to think of me as your "special" friend, someone here completely for you and the baby. I am here to talk when you need to share something that concerns you. I know that it is hard to start with a new baby and to have so much on your mind.

If the mother—or, if present, the father—is reluctant, the home visitor will ask if it is all right to come back the following week or offer a ride to the doctor, if needed.[10]

During the first 3 months of weekly visits, the primary focus is on helping the parents with basic family support, such as learning how to mix formula and wash the baby and understanding the baby's early

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stages of development and sleep patterns, as well as on answering the most common question, "Why does my baby cry so much?"

Family support plan. A great deal of the home visitor's time is spent listening to parents and providing emotional support; helping them obtain food, formula, and baby supplies; assisting them with housing and job applications; getting them to appointments; and providing informal counseling on a wide range of issues, including domestic violence and drug abuse. As one home visitor put it, "It's hard to teach the mother about child development when her eyes are only on her own crises." Therefore, early in their relationship, the home visitor and the family develop an Individual Family Support Plan, which lists the services that Healthy Start provides, plus assistance available from other social service agencies. The family checks the services they want to receive during the next 6 months. The plan spells out "What we want," "Ways to get it," "Who can help," "Target date," and "What happened." The parent(s), the home visitor, and the supervisor complete and sign the plan, which also records the other service providers involved with the family.

Assessing development. During the first few weeks, the home visitor watches for signs that the mother is bonding to the infant. If she is not, the visitor models the attachment behavior (e.g., showing the mother how to hold and talk to the baby while making eye contact).

Healthy Start mothers complete a series of Infant/Child Monitoring Questionnaires, designed to identify problems in child development at 4, 8, 12, 16, 20, 24, 30, 36, and 48 months. If necessary, the home visitor reads the questions to the mother.

Photo by Dannette Lyman

Bonding and attachment in infancy are crucial for the child to trust others as an adult.

Separate forms are used for girls and boys. Each form has five sections, covering communication, gross motor skills, fine motor skills, adaptive skills, and personal-social skills. Some questions asked at 4 months are:

- "Does your baby chuckle softly?"
- "While on her back, does your baby move her head from side to side?"
- "Does your baby generally hold her hands open or partly open?"
- "When you put a toy in her hand, does your baby look at it?"
- "When in front of a large mirror, does your baby smile or coo at herself?"

As part of its oversight, the Maternal Child Health Branch requires assessments at 4, 12, 20, and 30 months. If these reveal any developmental delays in the infant, assessments at 8, 16, and 24 months are performed. Periodic assessments are also used to determine when the family is stable enough for biweekly visits. The assessment is then repeated every 6 months to determine if visits can be safely reduced to every month, and then to every 3 months. Each family stays in the program until the child is 5 years old.

Meeting multiple needs. In addition to using the family support plan and the Infant/Child Monitoring Questionnaire, the program attempts to meet the families' multiple needs through the following:

- Parent skill building, individually and in groups, to provide parents with information about the needs of their children (primarily the newborn, but also older children) at each stage of development and what activities may be used to cope with these needs.
- Nursing Child Assessment Satellite Training (NCAST) assessment of feeding, the home, and teaching, in order to plan interventions.
- Interagency coordination and referrals.
- A toy-lending library.
- Parent support groups to increase self-esteem and reduce social isolation.

Some Healthy Start agencies in Hawai'i also provide these services:

- Respite care, to enable parents to participate in socialization groups, recreational activities, or parenting classes, or to attend to personal needs.
- A male home visitor who works with the father to reduce high-risk behavior.
- Parent-child play mornings to increase bonding and interaction.
- A child development specialist who monitors and tracks the child's development and coordinates referrals for developmental testing and services, as needed.

Focusing on child development. A major clinical challenge to Hawai'i Healthy

Photo by Dannette Lyman

A key component of Hawai'i's Healthy Start Program is to monitor infants' development.

Start has been how to strengthen the focus on child development. Most of the families served are described as "chaotic"; they are poor, live in substandard housing, are unemployed, and have emotional and frequently substance abuse problems. Home visitors are often caught up in the multiple and recurring crises of the parents and in helping the family deal with these immediate problems. This makes it difficult for the home visitor to turn the parents' attention to the child's emotional and social needs and to engage them in active intervention with the child.

Hawai'i Healthy Start has responded to this challenge in some of its agencies by adding child development specialists to the team. If the home visitor cannot fully address a child's developmental needs, a specialist goes to the home to teach the parents how to interact more constructively with their child. The crux of healthy development, in the view of Hawai'i Healthy Start, is to encourage parents to see their children as enjoyable and to play with them spontaneously.

Staff Qualifications, Training, and Supervision

Both home visitors and family assessment workers are required, at minimum, to have a high school degree or General Equivalency Degree. Several staff have completed some college work, while others have a bachelor's or associate's degree. Recruited through newspaper advertisements, they are interviewed first in groups of three or four and then individually. Each structured interview includes at least one sample vignette that asks the applicant to react to a specific situation. Ideally, applicants have been well-nurtured themselves, have strong social support systems, and have effective parenting skills. The presence of these attributes is established through extensive interviews about their childhood and the discipline they experienced.

All home visitors, family assessment workers, and supervisors attend a 6-week orientation, covering topics such as team building, child abuse and neglect, cultural sensitivity, child development, stress management, early identification of risk factors, supporting family growth, and promoting parent-child interaction and child development. Ten to 14 weeks later, staff receive an additional 2 weeks of training. Home visitors and family assessment workers receive at least 1 day of inservice training per quarter, plus informal training during case management sessions and weekly team meetings.

Family assessment workers. In addition to the training described above, family assesssment workers receive intensive training in interview techniques, the entire assessment process, and community referral sources. Every day, the supervisor reviews all screenings and assessment interviews for completeness and appropriate disposition. Because the family assessment workers work only 6 days a week and maternity stays are shrinking to 24 hours, some families are missed at the hospital and instead reached at home by telephone. A monthly log compares the number of births with the number of families screened and documents action taken for those not seen at birth. Also monthly, each supervisor shadows two family assessment workers and documents observations as they conduct an assessment. And, once a month, the supervisor calls two families who refused an interview or services to discuss the reasons why. Finally, once a year, 20 intake files are chosen at random for quality assurance review by management.

Home visitors. In addition to training received with other staff, home visitors are taught how to enter the home, work nonjudgmentally, and empower families. They also are trained in cultural competence regarding parenting and ways to promote mother/child bonding and child development.

Home visitors are sometimes matched ethnically to the family, but overall compatibility is the most important criterion in assignment. Some of the Hawai'i Healthy Start programs use male home visitors to work with families in which the father is involved with the child. Supervisors review the caseloads with each home visitor for 2 hours each week; the supervisory ratio is one to five or six. Home visitors' caseloads vary from 15 to 25 families, depending on the families' level of risk and the home visitor's experience. All home visitors work 40 hours per week, with a daily average of three 1 1/2 hour visits; the remaining time is spent on case management.

Links to the Criminal Justice System

While Healthy Start does not have formal working agreements with the criminal justice system in Hawai'i, it does collaborate with Family Court and related agencies, particularly in cases of domestic violence. A home visitor may accompany the mother or father to Family Court for support. The Court also may ask the home visitor for a report on the family to help decide a case's disposition. When warranted, the home visitor encourages the mother to develop a safety plan, including having telephone numbers for and transportation to the spouse abuse shelter and a bag packed with necessities for herself and her child(ren). The home visitor also encourages the batterer to attend anger management classes staffed and run by other community agencies. Where corresponding classes are available for partners, mothers are encouraged also to attend.

In addition, Healthy Start staff work closely with Hawai'i's victim assistance program. Healthy Start staff make presentations to victim advocates on the program's services and its clients' needs. In turn, victim advocates train program staff on court procedures and accept referrals, usually battered women who need assistance through the court system. On occasion, judges have referred pregnant women or new mothers involved in the criminal justice system to the program, but their participation is on a voluntary basis. When a mother is incarcerated at the time of birth, program staff try to work with her both before and after she is released. If the father is incarcerated, staff encourage family visits, if appropriate. Also, if the family has a probation or parole officer, staff try to coordinate services.

Hawai'i Healthy Start is linked directly to the criminal justice system through its aims to prevent child abuse and neglect. Another significant but more indirect link lies in Hawai'i Healthy Start's long-term potential to reduce later criminal behavior documented as characteristic of many child abuse and neglect victims. At the very least, a decreased rate of child mistreatment would represent a strong and positive step toward long-term crime prevention.

Evaluation

Internal outcome evaluation of Hawai'i Healthy Start has been conducted primarily in terms of confirmed cases of abuse and neglect. Between July 1987 and June 1991, 13,477 families were screened and/or assessed, 9,870 of which were determined to be at low risk. Of the 3,607 families at high risk, 1,353 were enrolled in Healthy Start, 901 were enrolled in less intensive home-visiting programs, and another 1,353 went unserved, due to limited program capacity.

Among the 1,353 Healthy Start families, the confirmed rates for abuse and neglect were 0.7 percent and 1.2 percent, respectively. The combined abuse/neglect (CAN) rate was 1.9 percent. The CAN rate for at-risk families not served was 5.0 percent, quite low, compared with results from studies using control groups denied services.[11] However, the percentage may actually be higher because the at-risk families not served in Hawai'i were not monitored for abuse and neglect, nor were their medical records reviewed. The 3.1 percent difference in CAN rates between Healthy Start and unserved at-risk families is a conservative estimate and represents about 42 cases prevented during the 4-year period. (The CAN rate for the 9,870 low-risk families was 0.3 percent.)[12]

At $15,000/case/year, the 42 fewer abuse and neglect cases attributable to Healthy Start between 1987 and 1991 represent a savings of over $1.26 million in child protection services (CPS) costs alone. (The average CPS case lasts 2 years.)

Although there are many other signs of the program's success (see "Indicators of Success for Hawai'i Healthy Start"), formal evaluation results are pending. Currently, two randomized control evaluations are being conducted, one by Deborah Daro and Karen McCurdy of the National Committee to Prevent Child Abuse (NCPCA), the other by Ann Duggan and Sharon Buchbinder of the Johns Hopkins University School of Medicine, Loretta Fuddy of Hawai'i Ma-

ternal and Child Care, and Calvin Sia.

In its second year, the NCPCA study is observing newborn to 18-month-old children served by the Hawai'i Family Stress Center at two locations on O'ahu. The study is looking at multiple outcomes—potential for child abuse, parenting skills, the mother's social support, the child's mental development, and the physical environment in the home. Results are expected in 1996.

The Johns Hopkins study is just starting. A prospective study, it will follow children throughout the State for 5 years. This study will cover child abuse and neglect, service delivery, adequacy of medical care, use of community resources, home environment, child health, child development, and school readiness. It will also include a cost/benefit analysis. Some data will be available in 3 years, but the entire study will not be completed until 1999.

Current Issues in Home Visitation

Heading into the late 1990's, home visitation programs like Hawai'i Healthy Start face significant questions regarding program structure and service delivery. Although much research remains to be conducted, several indepth studies provide evidence of the effectiveness of some home visiting programs and indicate what factors may lead to their success.

Breadth of services. Among the many program issues being discussed and researched are the breadth of services offered and the qualifications of staff who deliver the services. Although there appears to be a general consensus among researchers that home visitation programs should attempt to address a wide range of clients' needs, this view is tempered by the opinion that programs should have realistic expectations of what they can accomplish.[14] One review of randomized trials of home visitation programs designed to prevent child abuse and neglect found that programs with the most positive effects used comprehensive approaches to address a number of family needs.[15] Moreover, the successful programs provided both prenatal and postnatal services. (Recognizing the shortcoming of delaying outreach until birth, Hawai'i Healthy Start is currently planning a statewide program to provide prenatal care to all who need it.) Home visitation programs that, for instance, concentrate primarily on teaching mothers how to stimulate their infants' educational development or on providing only basic emotional support have shown little success.[16] It has been suggested that home visitation programs collaborate extensively with other community resources and service providers to address families' needs.[17]

Indicators of Success for the Hawai'i Healthy Start Program

Between July 1987 and June 1991, 2,254 families were served by Healthy Start. Indicators of the program's success over this 3-year period include:

- **Ninety percent of 2-year-olds in families receiving services were fully immunized.**
- **Eighty-five percent of the children in served families had developed appropriately for their ages.[13]**
- **Of the 90 families (4 percent) known to CPS at or prior to intake with a confirmed combined abuse/neglect report for siblings or imminent danger status, no further reports occurred during these families' program enrollment. Three cases were reported after the families left the program.**
- **No instances of domestic homicide have been recorded since the program's inception.**

Staff qualifications. Perhaps one of the more widely discussed questions regarding home visitation programs is whether professionals (particularly nurses) or paraprofessionals (usually individuals from the community with little advanced education) should be the primary service deliverers. Researchers and practitioners point to a number of advantages and disadvantages to using either professionals or paraprofessionals. It should be noted, however, that no systematic study comparing the two types of home visitors has been completed yet.

In general, professionals' expertise—and the confidence this inspires among clients and in themselves—seems to promote effective service delivery and more easily forestall job stress. One review indicated that programs with the most positive effects employed nurses as home visitors. However, it remains unclear whether the greater success stemmed from nurses' qualifications and training, clients' perceptions of nurses' qualifications, the comprehensiveness of services that programs with nurses tend to provide, or some other factor or combination of these.[18] The main disadvantages of nurses and other professionals are that they are expensive and scarce.

The majority of new home visiting programs, including Hawai'i Healthy Start, employ primarily paraprofessionals as service providers. Disadvantages of using

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paraprofessionals as home visitors include their relative lack of expertise and credibility, increased staff turnover due to job burnout, and need for extensive training and supervision. Also, although paraprofessionals may command smaller salaries than professionals, the level of training and supervision required may cancel out any potential financial savings to a program.[19] However, paraprofessionals from within the community being served may be better able to recruit families and communicate with them—because of shared beliefs, language or dialect, and experiences—than professionals outside that community. Paraprofessionals also may better serve as role models for clients.[20]

For example, Hawai'i Healthy Start staff say that the program's paraprofessionals establish rapport with families easily and are not threatening (as, staff say, professionals can be). Staff recruitment interviews specifically screen for people who are warm, caring, and nonjudgmental. Paraprofessionals are taught to accept the family "as it is" and to be patient with slow progress. In general, service deliverers from the community are considered necessary to obtain participants' trust.

Summary

As the criminal justice system increasingly focuses its attention on crime and violence reduction, the prevention of child abuse and neglect has become a critical priority. This approach takes on added urgency in light of research documenting the cycle of violence that begins with child mistreatment and can lead to later delinquency and criminal behavior. By providing comprehensive home visitation services to families at risk for child abuse and neglect, Hawai'i Healthy Start is taking an important step toward reducing both child abuse and later crime by many of its victims. As such, Hawai'i Healthy Start and similar home visitation programs may warrant the support of the criminal justice system and society.

Notes

[1] Cathy Spatz Widom, *The Cycle of Violence*, National Institute of Justice Research in Brief, Washington, DC: U.S. Department of Justice, 1992, 3; Widom, *Victims of Childhood Sexual Abuse—Later Criminal Consequences*, National Institute of Justice Research in Brief, Washington, DC: U.S. Department of Justice, 1995, 4.

[2] Richard J. Gelles and John W. Harrop, "The Nature and Consequences of the Psychological Abuse of Children: Evidence from the Second National Family Violence Survey." Paper presented at the Eighth National Conference on Child Abuse and Neglect, Salt Lake City, Utah, October 24, 1989.

[3] Source: John Walters, Hawai'i Department of Human Services.

[4] National Committee for Prevention of Child Abuse, *Child Abuse: Prelude to Delinquency?* Research Conference Findings, April 7–10, 1984, Washington, DC: Office of Juvenile Justice and Delinquency Prevention, U.S. Department of Justice, September 1986.

[5] See William DeJong, *Building the Peace: The Resolving Conflict Creatively Program (RCCP)*, National Institute of Justice Program Focus, Washington, DC: U.S. Department of Justice, 1994; DeJong, *Preventing Interpersonal Violence Among Youth: An Introduction to School, Community, and Mass Media Strategies*, National Institute of Justice Issues and Practices in Criminal Justice, Washington, DC: U.S. Department of Justice, 1994.

[6] *Healthy Start: Hawai'i's System of Family Support Services*, Honolulu: Hawai'i Department of Health, 1992, i.

[7] "Healthy Families America Third Year Progress Report," National Committee to Prevent Child Abuse, Chicago, IL, March 1995.

[8] Craig W. LeCroy and José B. Ashford, *Arizona Healthy Families First Year Outcome Evaluation Report*, Tucson, AZ: LeCroy, Ashford & Milligan, 1994, 13–14.

[9] The program hired an epidemiologist to determine this score. Using the results of the Kempe Family Stress Checklist as the measure of high and low risk, a score of two or more negative factors produces interviews of the largest percentage of high-risk families while avoiding interviews of the largest percentage of low-risk families (i.e., it maximizes the sum of specificity and sensitivity). About 4 to 5 percent of true high-risk families are missed by this criterion and are later reported to Child Protective Services. Even with these cases included, however, the Confirmed Abuse and Neglect rate of the noninterviewed families is less than 0.5 percent, which indicates that the criterion is very efficient.

[10] Vicki A. Wallach and Larry Lister, "Stages in the Delivery of Home-Based Services to Parents at Risk of Child Abuse: A Healthy Start Experience." Reprinted with permission of the *Journal of Scholarly Inquiry for Nursing Practice*, 9, no. 2, 1995 (in press). Published by Springer Publishing.

[11] Kempe found five confirmed cases in 25 control group families in Denver, and Olds found a 19 percent rate of confirmed abuse and neglect among a control group of poor, unmarried teenagers in Elmira, New York. See David Olds and Harriet Kitzman, "Can Home Visitation Improve the Health of Women and Children at Environmental Risk?" *Pediatrics*, 86, no. 1, 1990: 112.

[12] Loretta Fuddy, "Outcomes for the Hawai'i Healthy Start Program, 1992 (revised 1/94)," Honolulu: Hawai'i Department of Health, 1994. See also Gail Breakey and Betsy Pratt, "Healthy Growth for Hawai'i's Healthy Start: Toward a Systematic Statewide Approach to the Prevention of Child Abuse and Neglect," *Zero to Three*, April 1991.

[17] Loretta Fuddy, "Outcomes for the Hawai'i Healthy Start Program, 1992 (revised 1/94)."

[18] Deanna S. Gomby, Carol S. Larson, Eugene M. Lewit, and Richard E. Behrman, "Home Visiting: Analysis and Recommendations," *The Future of Children*, Center for the Future of Children, Los Altos, CA, 3, no. 3, Winter 1993: 18; Heather B. Weiss, "Home Visits: Necessary but Not Sufficient," *The Future of Children*, Center for the Future of Children, Los Altos, CA, 3, no. 3, Winter 1993: 120.

[19] David L. Olds and Harriet Kitzman, "Review of Research on Home Visiting for Pregnant Women and Parents of Young Children," *The Future of Children*, Center for the Future of Children: Los Altos, CA, 3, no. 3, Winter 1993: 88.

[20] Olds, "Can Home Visitation Improve the Health of Women and Children at Environmental Risk?" 113–114; Weiss, "Home Visits: Necessary but Not Sufficient," 120, 122.

[21] Weiss, "Home Visits: Necessary but Not Sufficient," 122–123.

[22] Olds, "Can Home Visitation Improve the Health of Women and Children at Environmental Risk?" 115.

[23] Douglas R. Powell, "Inside Home Visiting Programs," *The Future of Children*, Center for the Future of Children, Los Altos, CA, 3, no. 3, Winter 1993: 35–36.

[24] Barbara Hanna Wasik, "Staffing Issues for Home Visiting Programs," *The Future of Children*, Center for the Future of Children, Los Altos, CA, 3, no. 3, Winter 1993: 144–45.

About This Study

Ralph B. Earle, Ph.D., is an independent evaluator living in Hawai'i. The author reviewed the training materials, assessment instruments, and developmental materials for Hawai'i Healthy Start; interviewed Gail Breakey, Director of the Hawai'i Family Stress Center; and met with Healthy Start supervisors and staff. Julie Esselman, a research analyst at Abt Associates Inc., in Massachusetts, assisted the author. For further information, contact Gladys Wong, Program Head for Healthy Start, at (808) 946-4771.

COVER: The relaxed pose of these Healthy Start participants demonstrates that the program's goals—to reduce family stress and improve family functioning—are achievable and effective. (Photo by Dannette Lyman)

Findings and conclusions reported here are those of the author and do not necessarily reflect the official position or policies of the U.S. Department of Justice.

The National Institute of Justice is a component of the Office of Justice Programs, which also includes the Bureau of Justice Assistance, Bureau of Justice Statistics, Office of Juvenile Justice and Delinquency Prevention, and the Office for Victims of Crime.

NCJ 156216 October 1995

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